Baylor Scott & White HEALTH

Community Health Needs Assessment 2016

Baylor Scott & White Medical Center – Brenham

Baylor Scott & White Medical Center – College Station

The prioritized list of significant health needs has been presented and approved by the hospital facilities' governing body, and the full assessment must be made available to the public at no cost for download on our website at BaylorScottandWhite.com/CommunityNeeds or upon request. Retain this document through the fiscal year ending June 30, 2020.

Approved by: Baylor Scott & White Health - Central Texas Operating, Policy and Procedure Board on April 22, 2016 and Baylor Scott & White Medical Cetner - Brenham Board of Directors on April 27, 2016
Posted to BaylorScottandWhite.com/CommunityNeeds on June 30, 2016

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Baylor Scott & White Health Mission Statement

OUR MISSION

Baylor Scott & White Health exists to serve all people by providing personalized health and wellness through exemplary care, education and research as a Christian ministry of healing.

“Personalized health” refers to our commitment to develop innovative therapies and procedures focusing on predictive, preventive and personalized care. For example, we’ll use data from our electronic health record to help us predict the possibility of disease in a person or a population. And with that knowledge, we can put measures in place to either prevent the disease altogether or significantly decrease its impact on the patient or the population. We’ll tailor our care to meet the individual medical, spiritual and emotional needs of our patients.

“Wellness” refers to our ongoing effort to educate the people we serve, helping them get healthy and stay healthy.

“Christian ministry” reflects the heritage of Baylor Health Care’s founders and Drs. Scott and White, who showed their dedication to the spirit of servanthood — to equally serve people of all faiths and those of none.

WHO WE ARE

In 2013, Baylor Health Care System and Scott & White Healthcare became one.

The largest not-for-profit health care system in Texas, and one of the largest in the United States, Baylor Scott & White Health (BSWH) was born from the 2013 combination of Baylor Health Care System and Scott & White Healthcare.

Known for exceptional patient care for more than a century, the two organizations serve adjacent regions of Texas and operate on a foundation of complementary values and similar missions. Baylor Scott & White Health includes 41 licensed hospitals, more than 900+ patient care sites, more than 6,600 active physicians, 43,750+ employees and the Scott & White Health Plan.

Over the years, Baylor and Scott & White have worked together as members of the High Value Healthcare Collaborative, the Texas Care Alliance and Healthcare Coalition of Texas and are two of the best known, top-quality health care systems in the country, not to mention in Texas.

After years of thoughtful deliberation, the leaders of Baylor Health Care System and Scott & White Healthcare decided to combine the strengths of the two health systems and create a new model system able to meet the demands of health care reform, the changing needs of patients and extraordinary recent advances in clinical care.

With a commitment to and a track record of innovation, collaboration, integrity and compassion for the patient, Baylor Scott & White Health stands to be one of the nation's exemplary health care organizations.

OUR CORE VALUES & QUALITY PRINCIPLES

Our values define our culture and should guide every conversation, decision and interaction we have with each other and with our patients and their loved ones:

- *Integrity*: Living up to high ethical standards and showing respect for others
- *Servanthood*: Serving with an attitude of unselfish concern
- *Teamwork:* Valuing each other while encouraging individual contribution and accountability
- *Excellence*: Delivering high quality while striving for continuous improvement
- *Innovation*: Discovering new concepts and opportunities to advance our mission
- *Stewardship*: Managing resources entrusted to us in a responsible manner

Executive Summary

As the largest not-for-profit health care system in Texas, BSWH understands the importance of serving the health needs of its communities. And in order to do that successfully, we must first take a comprehensive look at the issues our patients, their families and neighbors face when it comes to making healthy life choices and health care decisions.

Beginning in the summer of 2015, a BSWH task force led by the community benefit, tax compliance, and corporate marketing departments began the process of assessing the current health needs of the communities we serve for all BSWH hospitals. Truven Health Analytics was engaged to help collect and analyze the data for this process and to compile a final report made publicly available in June of 2016.

BSWH owns and operates multiple individual licensed hospital facilities serving the residents of North and Central Texas. Certain of these hospital facilities have overlapping communities and have collaborated to conduct a joint community health needs assessment. This joint community health needs assessment applies to the following BSWH hospital facilities:

- Baylor Scott & White Medical Center – Brenham
- Baylor Scott & White Medical Center – College Station

For the 2016 assessment, Baylor Scott & White Medical Center – Brenham and Baylor Scott & White – College Station have defined their community to be the geographical area of Austin, Burleson, Brazos, Grimes, Waller and Washington counties. The community served was determined based on the counties that make up at least 75 percent of the hospital facilities' inpatient and outpatient admissions over a period of the past 12 months. Once the counties were identified those facilities with overlapping counties of patient origin collaborated to provide a joint CHNA report in accordance with the Treasury regulations. All of the collaborating hospital facilities included in this joint CHNA report define their community, for purposes of the CHNA report, to be the same.

With the aid of Truven Health Analytics, we examined nearly 70 public health indicators and conducted a benchmark analysis of this data comparing the community to overall state of Texas and U.S. values. For a qualitative analysis, and in order to get input directly from the community, we conducted focus groups that included representation of minority, underserved and indigent populations' needs and interviewed several key informants in the community that were community leaders and public health experts.

Needs were first identified when an indicator for the community served did not meet state benchmarks. An index of magnitude analysis was then conducted on all the indicators that did not meet state benchmarks to determine the degree of difference from benchmark in order to indicate the relative severity of the issue. The outcomes of this quantitative analysis were aligned with the qualitative findings of the community input sessions to bring forth a list of health needs in the community. These health needs were then classified into one of four quadrants within a health needs matrix; high data low qualitative, low data low qualitative, low data high qualitative, or high data high qualitative.

The matrix was reviewed by hospital and clinic leadership in a session to establish a list of significant needs and to prioritize them. The meeting was moderated by BSWH –

Central Texas Director of Community Benefit and included an overview of the community demographics, summary of health data findings, and an explanation of the quadrants of the health needs matrix.

Participants all agreed that the health needs indicated in the quadrant labeled “high qualitative, high quantitative” deserved the most attention, and there was discussion around which indicators from that quadrant should be identified as significant.

A dotmocracy[1] voting method was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 of the health needs identified in the matrix. The votes were tallied and priority needs were established by the highest number of votes and are displayed in order of number of votes received.

1. Mental Health
2. Chronic Illness
3. Cancer
4. Obesity
5. Access to Specialty Providers
6. Resources for the Elderly

Also as part of the assessment process, we have distinguished both internal resources and community resources and facilities that may be available to address the significant needs in the community. They are identified in the body of this report and will be included in the formal implementation strategy to address needs identified in this assessment that will be approved and made publicly available by the 15th day of the 5th month following the end of the tax year.

An evaluation of the impact and effectiveness of interventions and activities outlined in the implementation strategy drafted after the 2013 assessment was also completed and is included in Appendix C of this document.

The prioritized list of significant health needs has been presented and approved by the hospital facilities’ governing body and the full assessment is available to the public at no cost for download on our website at BaylorScottandWhite.com/CommunityNeeds.

This assessment and corresponding implementation strategies are intended to meet the requirements for community benefit planning and reporting as set forth in state and federal laws, including but not limited to: Texas Health and Safety Code Chapter 311 and Internal Revenue Code Section 501(r).

[1] “Dotmocracy” is an established facilitation method used to describe voting with dot stickers, also known as “multi-voting”. In Dotmocracy participants vote on their favorite options using a limited number of stickers or marks with pens — dot stickers being the most common. This sticker voting approach is a form of cumulative voting.

Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years. A CHNA is a written document developed for a hospital facility that defines the community served by the hospital facility; the process used to conduct the assessment including how the hospital took into account input from community members including those from public health department(s) and members or representatives of medically underserved, low-income, and minority populations; identification of any organizations with whom the hospital has worked on the assessment; and the significant health needs identified through the assessment process.

The written CHNA Report must include descriptions of the following:

- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify significant community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized community health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs
- The existing health care facilities and other resources within the community available to meet the significant community health needs
- An evaluation of the impact of any actions that were taken, since the hospital facility(s) most recent CHNA, to address the significant health needs identified in that last CHNA

PPACA also requires hospitals to adopt an Implementation Strategy to address prioritized community health needs identified through the assessment. An Implementation Strategy is a written plan that addresses each of the significant community health needs identified through the CHNA and is a separate but related document to the CHNA report.

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify data sources that will be used to track the plan's impact)
- Identify programs and resources the hospital plans to commit to address the health needs
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital's governing body and made widely available to the public. The Implementation Strategy is considered adopted on the date it is approved by the governing body. Organizations must approve and make public their Implementation Strategy by the 15th day of the 5th month following the end of the tax year. CHNA compliance is reported on IRS Form 990, Schedule H.

This assessment is also intended to meet the requirements for community benefit planning and reporting as set forth in the Texas Health and Safety Code Chapter 311 applicable to Texas nonprofit hospitals.

Baylor Scott & White Health: Community Health Needs Assessment Overview, Methodology and Approach

BSWH partnered with Truven Health Analytics (Truven Health) to complete a CHNA for the BSWH facilities.

Consultant Qualifications & Collaboration

Truven Health and its legacy companies have been delivering analytic tools, benchmarks, and strategic consulting services to the healthcare industry for over 50 years. Truven Health combines rich data analytics in demographics (including the Community Needs Index, developed with Catholic Healthcare West, now Dignity Health), planning, and disease prevalence estimates with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments.

Defining the Community Served

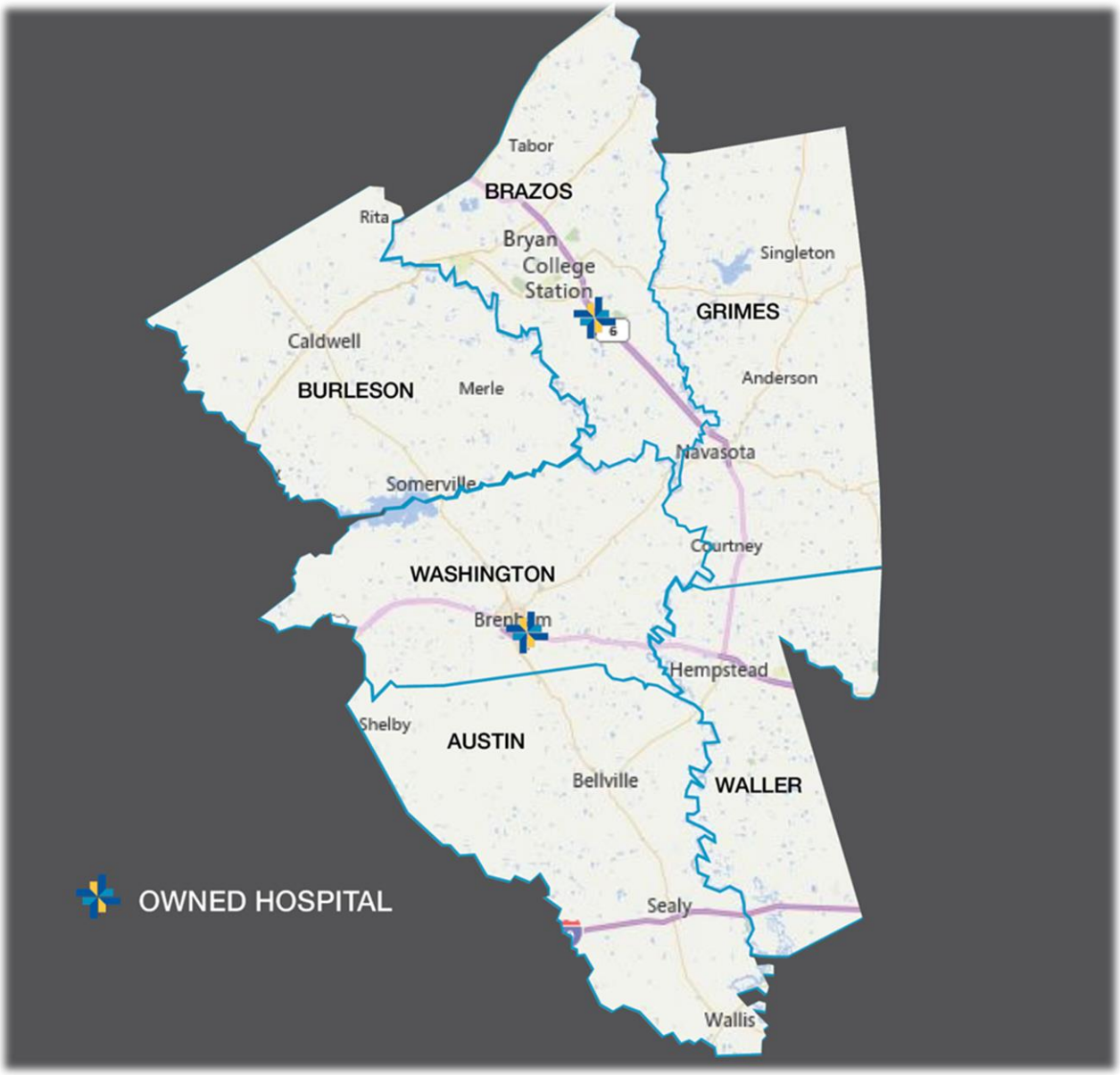
BSWH owns and operates multiple individual licensed hospital facilities serving the residents of North and Central Texas. Certain of these hospital facilities have overlapping communities and have collaborated to conduct a joint community health needs assessment. The community served definitions used in this current assessment differ from those used by the legacy Baylor Health Care System and the legacy Scott & White Healthcare in their 2013 CHNAs.

BSWH, has chosen a common methodology and approach to define the communities served for each of its facilities. BSWH identified the counties accounting for at least 75 percent of each facility's total volume (based on the most recent 12 months of inpatient and outpatient data). Once the counties were identified, those facilities with overlapping counties of patient origin collaborated to produce a joint CHNA report, in accordance with the Treasury regulations. All of the collaborating hospital facilities included in this joint CHNA report define their community for purposes of the CHNA report to be the same.

BSWH Community Health Needs Assessment Community Served Definition

For the 2016 assessment, the hospital facilities have defined their community to be the geographical area of Austin, Brazos, Burleson, Grimes, Waller and Washington counties. The community served was determined based on the counties that make up at least 75 percent of the hospital's inpatient and outpatient admissions.

BSWH Community Health Needs Assessment
Map of Community Served



Assessment of Health Needs – Methodology and Data Sources

To assess the health needs of the community served, a quantitative and qualitative approach was taken. In addition to collecting data from a number of public and Truven Health proprietary sources, interviews and focus groups were conducted with individuals representing public health, community leaders/groups, public organizations and other providers.

Quantitative Assessment of Health Needs

Quantitative data in the form of public health indicators were collected and analyzed to assess community health needs. Eight categories of seventy-nine indicators were collected and evaluated for the counties where data was available. The categories and indicators are included in the table below and the sources of these indicators can be found in ***Appendix A***.

Population
- High School Graduation Rate
- High School Drop Outs
- Some College
- Births to Unmarried Women
- Children in Poverty
- Children in Single-Parent Households
- Income Inequality
- Poverty
- Disability
- Social Associations
- Children Eligible for Free Lunch
- Homicides
- Violent Crime

Injury & Death
- Heart Disease Death Rate
- Overall Cancer Death Rate
- Chronic Lower Respiratory Disease (CLRD) Death Rate
- Stroke Death Rate
- Infant Mortality
- Child Mortality
- Premature Death
- Motor Vehicle Crash Mortality Rate

Mental Health
- Mental Health Providers
- Poor Mental Health Days

Prevention
- Diabetic Screening
- Mammography Screening
- Flu Vaccine 65+

Health Outcomes
- Poor or Fair Health
- Average Number of Poor Physical Unhealthy Days in Past Month
- Cancer (all causes) Incidence
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Diabetes
- Stroke
- Arthritis
- Alzheimer's/ Dementia
- Atrial Fibrillation
- COPD
- Kidney Disease
- Depression
- Heart Failure
- Hyperlipidemia
- Heart Disease
- Schizophrenia
- Osteoporosis
- HIV Prevalence
- Prenatal Care
- Smoking During Pregnancy
- Low Birth Rate
- Very Low Birth Rate
- Preterm Births

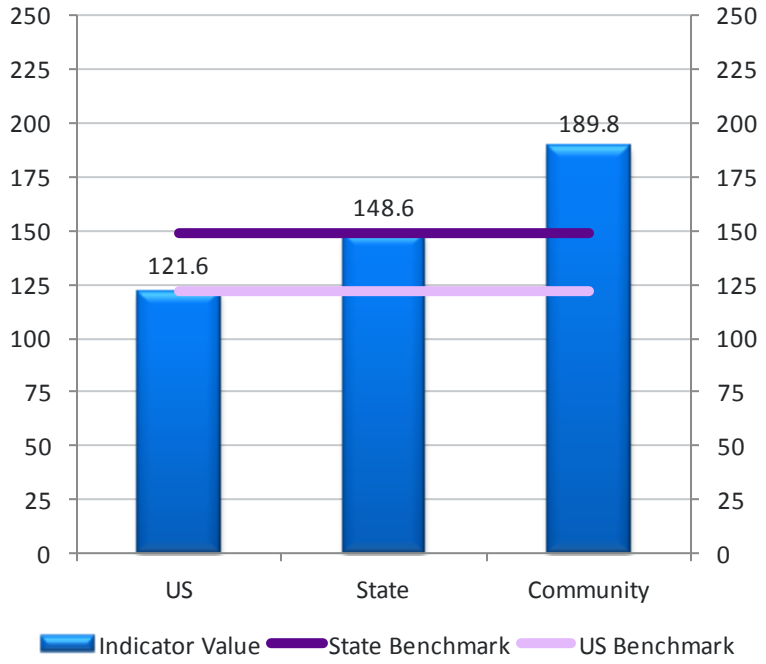
Health Behaviors
- Obesity
- Childhood Obesity
- Physical Inactivity
- No Exercise
- Adult Smoking
- Excessive Drinking
- Teen Birth Rate
- Sexually Transmitted Infections
- Alcohol Impaired Driving Deaths
- Drug Poisoning Deaths

Access to Care
- Uninsured
- Uninsured Children (<17)
- Could Not See a Doctor Due to Cost
- Other Primary Care Providers
- Dentists
- Preventable Hospital Stays
- Affordability of Healthcare
- Healthcare Costs

Environment
- Limited Access to Healthy Foods
- Food Insecurity
- Food Environment Index
- Access to Exercise Opportunities
- Air Quality/ Pollution
- Drinking Water
- Housing
- Commute/ Long
- Commute/ Alone

In order to determine which public health indicators demonstrate a community health need, a benchmark analysis was conducted for each indicator collected for the community served. Benchmark health indicators collected included (when available); overall US values, state of Texas values, and goal setting benchmarks such as Healthy People 2020 and/or County Health Rankings Best Performer values.

Health Indicator Benchmark Analysis Example



According the America's Health Rankings, Texas ranks 34th out of the 50 states. The health status of Texas compared to other states in the nation identifies many opportunities to impact health within local communities even for those communities that rank highly within the state. Therefore, the benchmark for the community served was set to the state value. Needs are identified when one or more of the indicators for the community served do not meet state benchmarks. An index of magnitude analysis was then conducted on those indicators that did not meet state benchmarks in order to understand to what degree they differ from benchmark in order to understand their relative severity of need.

The outcomes of the quantitative data analysis were then compared to the qualitative data findings.

Qualitative Assessment of Health Needs (Community Input)

In addition to analyzing quantitative data, focus groups with a total of six (6) participants, as well as nine (9) key informant interviews, were conducted September through November 2015 in order to take into account the input of persons representing the broad interests of the community served. The focus groups and interviews were conducted to solicit feedback from leaders and representatives who serve the community and have insight into community needs.

The focus group is designed to familiarize participants with the CHNA process and gain a better understanding of priority health needs from the community's perspective. Focus groups were formatted for individual as well as small group feedback and also helped identify other community organizations already addressing health needs in the community.

Truven Health also conducted key informant interviews for the community served. The interviews were designed to help understand and gain insight into how participants feel about the general health status of the community and the various drivers contributing to health issues.

In order to qualitatively assess the health needs for the community, participation was solicited from at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community; as well as individuals or organizations serving and/or representing the interests of medically underserved, low-income and minority populations in the community.

In order to ensure the input received also represented the broad interests of the community served, participation was also sought from community leaders/groups, public health organizations, other healthcare organizations and other healthcare providers (including physicians).

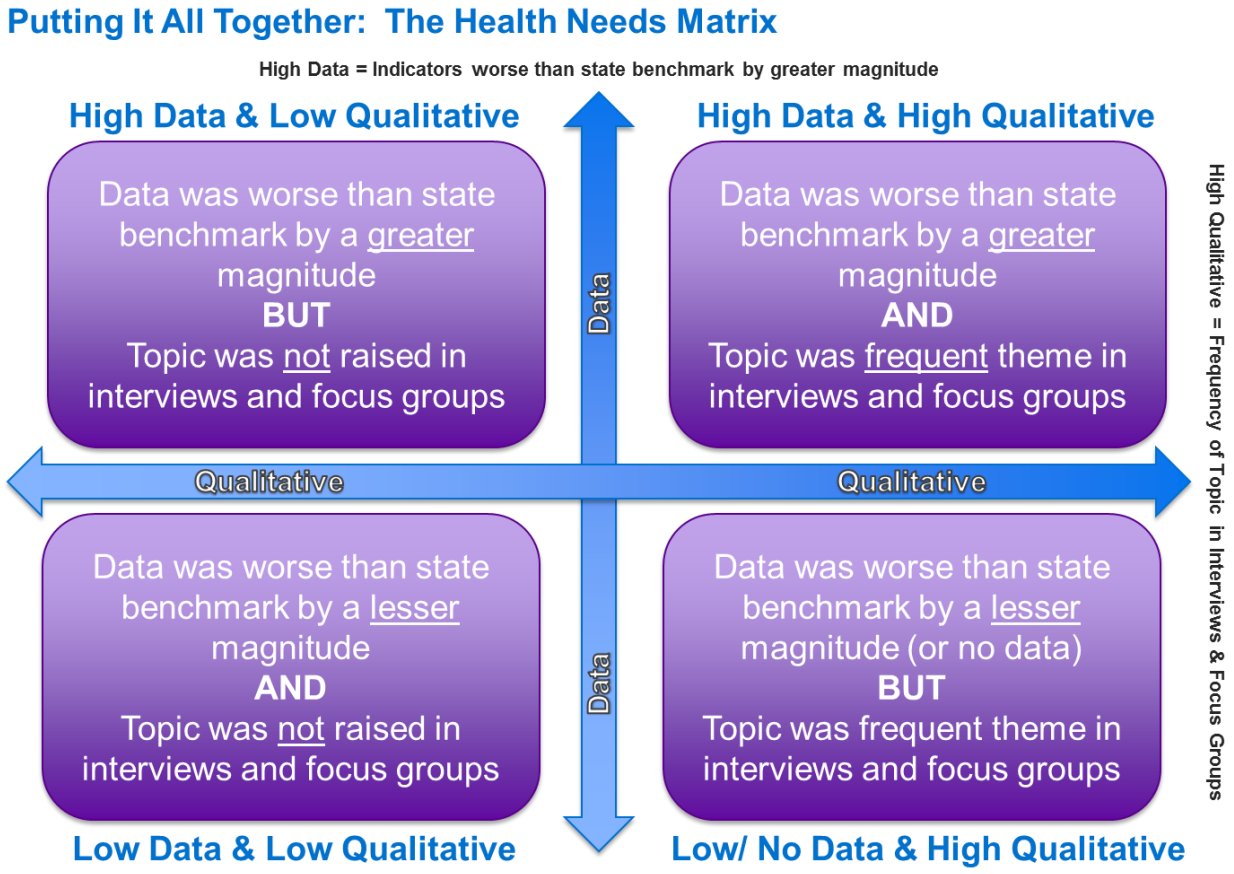
In addition to soliciting input from public health and various interests of the community, hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies. The facilities have an active portal on the website (CHNA.sw.org) where the assessment has been made available asking for public comment or feedback on the report findings. To date we have not received such written input but continue to welcome feedback from the community.

Input collected from the participants during the interviews and focus groups were organized into themes around community needs and compared to the quantitative data findings.

Methodology for Defining Community Need

Using qualitative feedback from the interviews and focus group, as well as the health indicator data, the issues currently impacting the community served were consolidated and assembled in the Health Needs Matrix below in order to help identify the significant health needs for each community served.

The upper right quadrant of the matrix is where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge.



Source: Truven Health Analytics, 2016

Information Gaps

The majority of public health indicators are only available at the county level and in Texas health indicators are not available for every county due to variation in population density. In evaluating data for entire counties versus more localized data, it was difficult to understand the health needs for specific population pockets within a county. It can also be a challenge to tailor programs to address community health needs as placement, and access to those programs in one part of the county may or may not actually impact the population who truly need the service. Truven Health supplemented health indicator data with Truven Health's ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

Existing Resources to Address Health Needs

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. A description of these resources is provided in ***Appendix B***.

Prioritizing Community Health Needs

The prioritization of community health needs identified through the assessment was based on the weight of quantitative and qualitative data obtained when assessing the community and included an evaluation of the severity of each need as it pertains to the state benchmark, value the community places on the need and prevalence of the needs within the community. A thorough description of the process can be found in the "Prioritizing Community Health Needs" section of the assessment.

The prioritized needs were reviewed and/or approved by senior management, hospital advisory board members, governing board members and the BSWH governing board.

Evaluation of Implementation Strategy Impact

As part of the current assessment, BSWH conducted an evaluation of the implementation strategies adopted as part of the 2013 CHNAs. In 2013, the hospital facilities chose to address the following identified needs:

- Obesity
- Chronic disease
- Resources for the elderly
- Disparity in access for low income and minority persons
- Mental health services

Implementation strategies were put into place in 2013 to address the above needs. Those strategies have been evaluated as to their effectiveness and impact. Details for that evaluation can be found in ***Appendix C***.

Demographic and Socioeconomic Summary

According to population statistics, the community served is fairly representative of Texas overall. The area does differ somewhat from the state as it relates to socioeconomic barriers. The community served has fewer Medicaid beneficiaries and more uninsured individuals than the state. The median household income is lower in the community served with Brazos County having a significantly higher percent of people living in poverty when compared to the state.

Demographic and Socioeconomic Comparison: Community Served and State/US Benchmarks

Demographic / Socioeconomic Variable	Benchmarks		Community Served
	United States	Texas	
Total Current Population	319,459,991	27,037,393	356,864
5 Yr Proj Pop Chg	4%	7%	6%
Population 0-17	23%	26%	22%
Population 65+	15%	12%	12%
Women Age 15-44	20%	21%	24%
Non-White Population	29%	31%	30%
Insurance Coverage: Medicaid	19%	14%	11%
Insurance Coverage: Uninsured	10%	20%	31%
Median Household Income	$56,682	$56,653	$45,802
Limited English	5%	8%	4%
No High School Diploma	14%	19%	17%
Unemployed	10%	8%	8%
Poverty	16%	18%	Austin Co: 10%
			Burleson Co: 16%
			Brazos Co: 29%
			Grimes Co: 19%
			Waller Co: 19%
			Washington Co: 14%

Source: Truven Health Analytics / The Nielsen Company, 2015

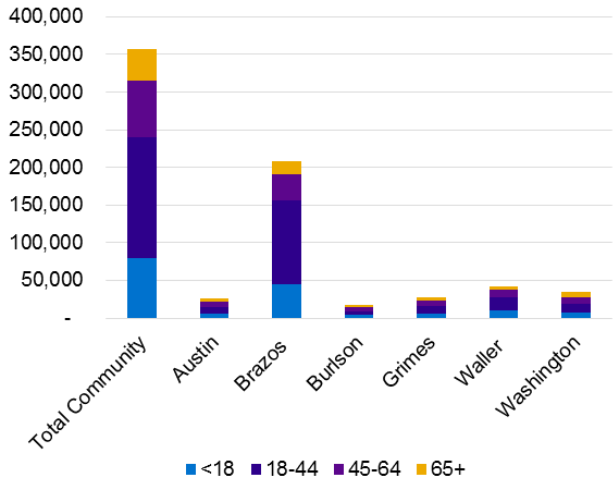
The population of the community served is expected to grow 6% by 2020, an increase by more than 40,000 people, by 2020. The 6% population growth is minimally lower than the state's growth rate (6.7%) and higher compared to the national growth rate (4%). The ZIP Codes expected to experience the most growth in five years are:

- 77845 College Station – 5,343 people
- 77840 College Station – 2,381 people

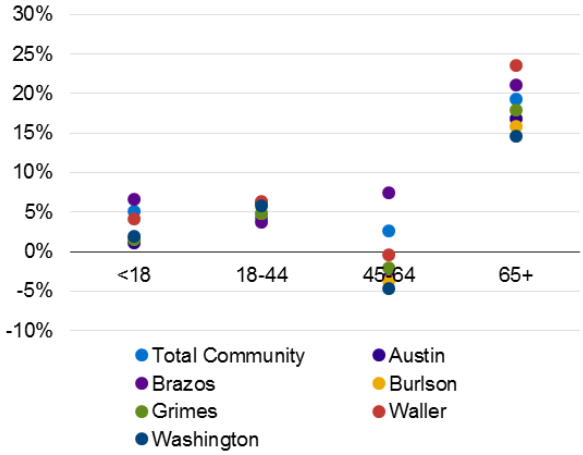
The sixty-five plus cohort was the smallest but is expected to experience the most growth over the next five years, adding nearly 8,000 seniors to the community. Growth in this population will likely contribute to increased utilization of services as the population continues to age. Meanwhile, 45 and 64 year old cohort is expected to decrease except in Brazos County where it is expected to grow by 2,500 lives.

Population by Age Cohort

2015 Total Population



5 Year Projected Population Growth Rate

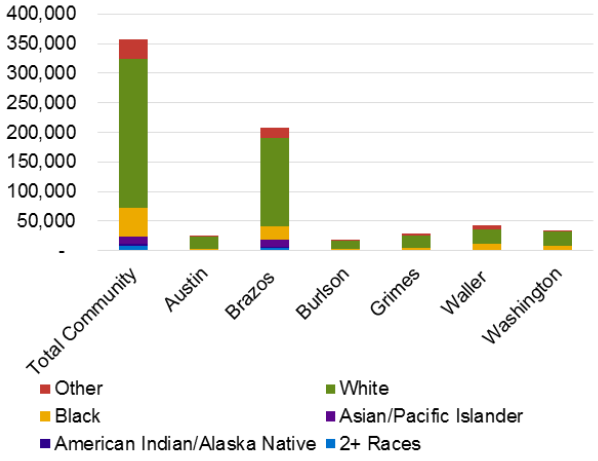


Source: Truven Health Analytics / The Nielsen Company, 2015

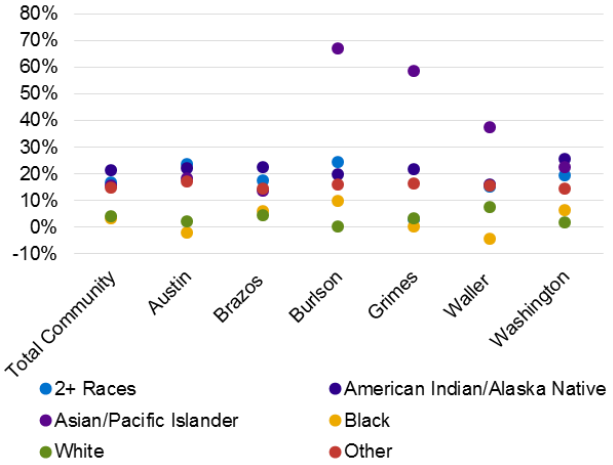
Diversity in the community will increase as minority populations are expected to grow the fastest. The white population is expected to remain relatively flat; however, the black population is projected to decline by 4.4% over the next 5 years. The Asian / Pacific Islander, multi-racial and American Indian / Native American populations are all expected to experience growth over the next 5 years. Total population can be analyzed by race or by Hispanic ethnicity. The graphs below display the community's total population breakdown by race (including all ethnicities) and also by ethnicity (including all races).

Population by Race

2015 Total Population



5 Year Projected Population Growth Rate

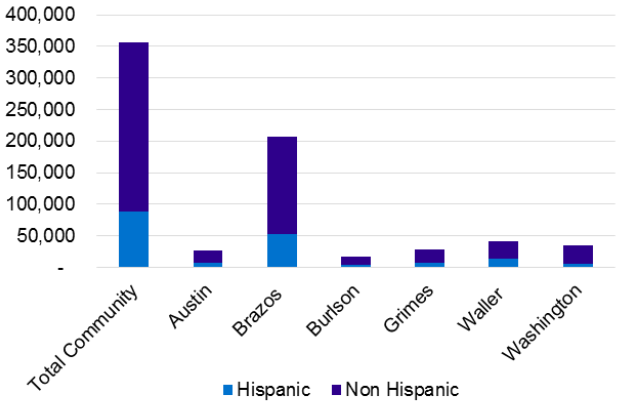


Source: Truven Health Analytics / The Nielsen Company, 2015

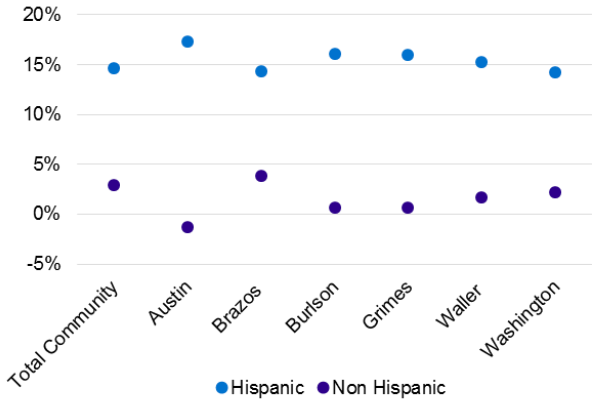
The growth of the Hispanic population in the community is projected to far exceed that of the non-Hispanic population with 24,012 Hispanic individuals being added to the community over the next 5 years.

Population by Hispanic Ethnicity

2015 Total Population



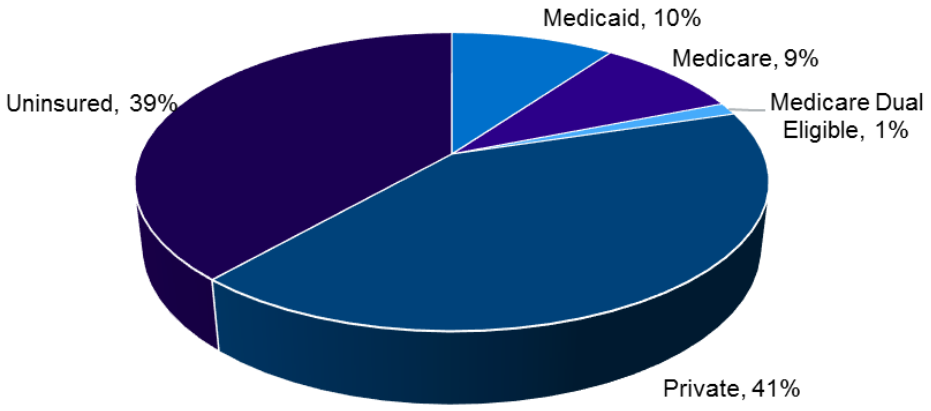
5 Year Projected Population Growth Rate



Source: Truven Health Analytics / The Nielsen Company, 2015

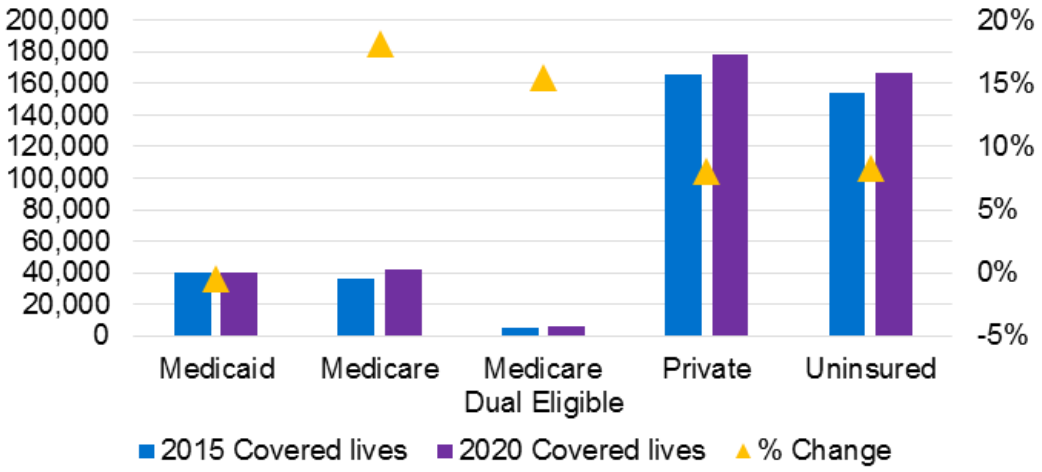
The median household income for the community served was $45,802. Forty-one percent (41%) of the community was privately insured, which is equivalent to 165,363 covered lives. The population purchasing insurance through the health insurance exchange marketplace is expected to increase from 10% of the privately insured to 20% by 2020. Medicaid covers 39,927 (11%) lives, 154,382 (39%) are uninsured, and 41,231 (10%) are covered by Medicare or are Medicare Dual Eligible. The uninsured population is not projected to experience any change over the next 5 years.

2015 Estimated Distribution of Covered Lives by Insurance Category



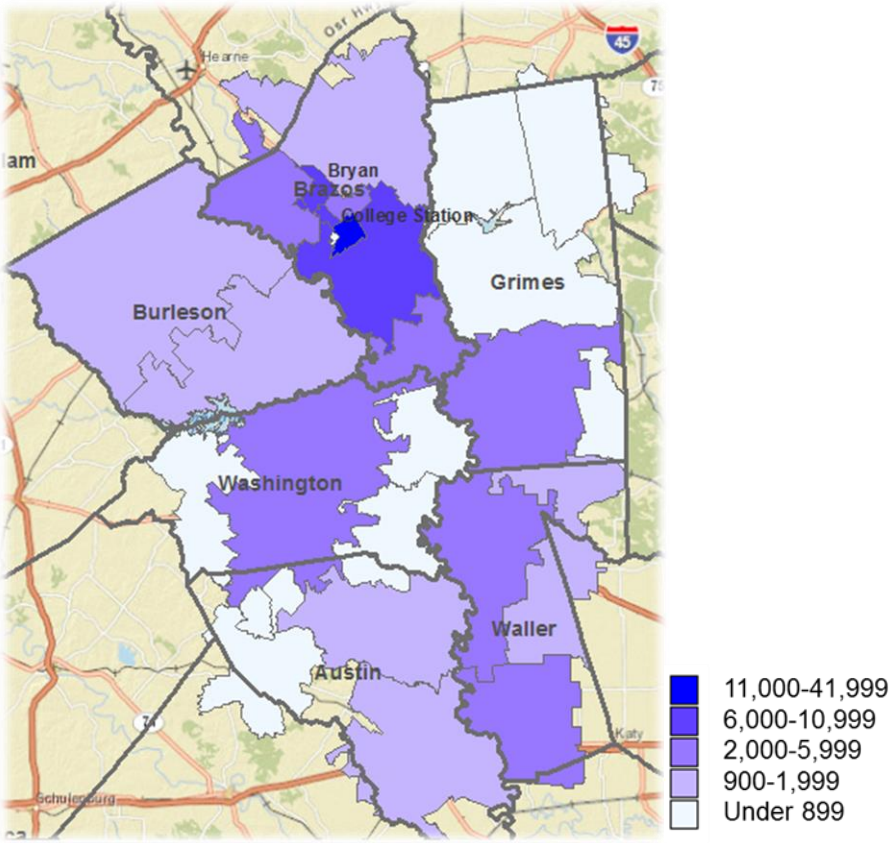
Source: Truven Health Analytics, 2015

Estimated Covered Lives and Projected Growth by Insurance Category



Source: Truven Health Analytics, 2015

2015 Estimated Uninsured Lives by ZIP Code



Source: Truven Health Analytics, 2015

The community includes sixteen (16) Health Professional Shortage Areas and six (6) Medically Underserved Areas as designated by the U.S. Department of Health and Human Services Health Resources Services Administration.[2] ***Appendix D*** includes the details on each of these designations.

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016

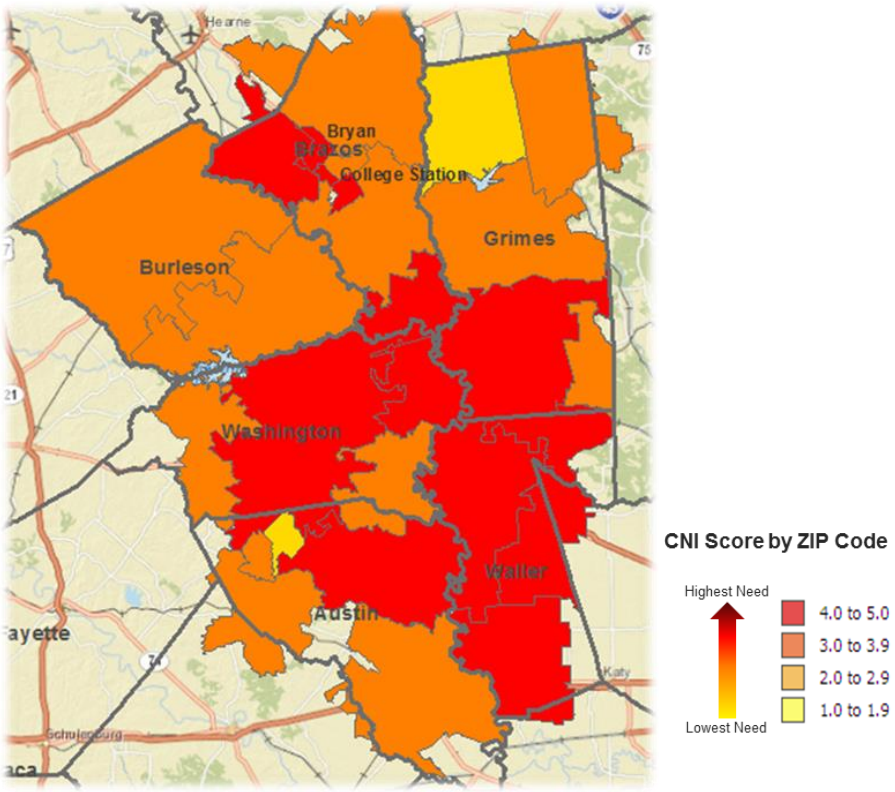
Health Professional Shortage Areas and Medically Underserved Areas and Populations

	Health Professional Shortage Area (HPSA)				Medically Underserved Area/Population (MUA/P)
COUNTY	Dental Health	Mental Health	Primary Care	TOTAL HPSA	TOTAL MUA/P
Austin County	0	1	1	2	1
Brazos County	1	2	2	5	1
Burleson County	1	1	1	3	1
Grimes County	0	1	1	2	1
Waller County	0	1	1	2	1
Washington County	0	1	1	2	1
TOTAL	**2**	**7**	**7**	**16**	**6**

The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the community served was above the CNI national average. However, there were portions of the community (Bryan, Hempstead, and Navasota) where we estimated very significant health needs. The community had an overall CNI Score of 3.9

2015 Community Need Index by ZIP Code



Source: Truven Health Analytics, 2015

Public Health Indicators

Public health indicators were collected and analyzed to assess community health needs. Sixty-nine indicators were evaluated for the community served. For each health indicator, a comparison was made between the most recently available community data and benchmarks for the same/similar indicator. Benchmarks were based on available data and included the United States and the State of Texas. Health needs were identified where the community indicators did not meet the State of Texas comparative benchmark. The indicators that did not meet the state benchmark for this community include the following:

Category	Indicator
Access to care	Percentage of population under age 65 without health insurance
Access to care	Percent Uninsured Children (<17)
Access to care	Could not see doctor due to cost
Access to care	Ratio of population to one primary care physician
Access to care	Ratio of population to one non-physician primary care provider
Access to care	Ratio of population to one dentist
Access to care	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Environment	Food Insecure Households (percent)
Environment	Limited access to healthy foods (percent of low income)
Environment	Food environment index
Environment	Population with adequate access to locations for physical activity (percent)
Environment	Drinking water violations (percent of population exposed)
Environment	Severe housing problems (percent of households)
Environment	Driving alone to work (percent of workforce)
Environment	Long commute - driving alone (percent of workers who commute by car)
Health behaviors	Adult Obesity (percent)
Health behaviors	Physical Inactivity (percent)
Health behaviors	No Exercise (percent)
Health behaviors	Adult Smoking (percent)
Health behaviors	Adults Engaging in Binge Drinking During the Past 30 Days (percent)
Health behaviors	Driving deaths with alcohol involvement (percent)
Health behaviors	Number of drug poisoning deaths (per 100,000)
Health behaviors	Teen birth rate per 1,000 female population, ages 15-19
Health behaviors	Sexually Transmitted Infection Incidence Rate (per 100,000)
Health outcomes	Percentage of adults reporting fair or poor health (age-adjusted)
Health outcomes	Average number of physically unhealthy days reported in past 30 days (age-adjusted)
Health outcomes	Cancer (all causes) Incidence
Health outcomes	Female Breast Cancer Incidence
Health outcomes	Colon Cancer Incidence (per 100,000)
Health outcomes	Lung Cancer Incidence (per 100,000)
Health outcomes	Prostate Cancer Incidence (per 100,000)
Health outcomes	Adults Reporting Diagnosed w/ Diabetes (percent)
Health outcomes	Hypertension: Medicare Population (percent)
Health outcomes	Stroke: Medicare Population (percent)
Health outcomes	Alzheimer's Disease/Dementia: Medicare Population (percent)
Health outcomes	Atrial Fibrillation: Medicare Population (percent)
Health outcomes	COPD: Medicare Population (percent)
Health outcomes	Chronic Kidney Disease: Medicare Population (percent)
Health outcomes	Depression: Medicare Population (percent)
Health outcomes	Heart Failure: Medicare Population (percent)
Health outcomes	Hyperlipidemia: Medicare Population (percent)
Health outcomes	Ischemic Heart Disease: Medicare Population (percent)
Health outcomes	Schizophrenia and Other Psychotic Disorders: Medicare Population (percent)
Health outcomes	Pediatric Asthma Admission Risk-Adjusted-Rate (per 100,000)
Health outcomes	Adult Perforated Appendix Admission Risk-Adjusted-Rate (per 100 Admissions for Appendicitis)
Health outcomes	Adult Uncontrolled Diabetes Admission Risk-Adjusted-Rate(per 100,000)

Category	Indicator
Health outcomes	Adult Risk-Adjusted-Rate of Lower-Extremity Amputation Among Patients with Diabetes (per 100,000)
Health outcomes	First trimester entry into prenatal care
Health outcomes	Births to Mothers Who Smoked During Pregnancy
Health outcomes	Low Birth Weight Rate (per 100 births)
Health outcomes	Preterm Births <37 weeks gestation
Injury & death	Heart Disease Death Rate (per 100,000)
Injury & death	Cancer Deaths total (per 100,000)
Injury & death	Chronic Lower Respiratory Disease (CLRD) Death Rate (per 100,000)
Injury & death	Stroke Death Rate (per 100,000)
Injury & death	Premature Death (potential years lost)
Injury & death	Infant Mortality (rate per 1,000)
Injury & death	Child Mortality Rate (per 100,000)
Injury & death	Motor Vehicle Crash Mortality Rate (per 100,000)
Mental health	Ratio of population to one mental health provider.
Population	High School Graduation Rate
Population	High School Dropouts (Percent)
Population	Some College (percent)
Population	Children in Poverty (Percent)
Population	Children in Single-parent Households
Population	Unemployment (percent)
Population	Income inequality
Population	Individuals Living Below Poverty Level
Population	Individuals Who Report Being Disabled (percent)
Population	Social associations (membership associations per 10,000 population)
Population	Percentage of children enrolled in public schools that are eligible for free lunch
Population	Number of deaths due to homicide per 100,000 population
Prevention	Diabetic monitoring: Medicare Enrollees
Prevention	Mammography Screening: Medicare Enrollees
Prevention	Flu Vaccine 65+

Truven Health Community Data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence of heart disease and cancer as well as emergency department visit estimates.

Unsurprisingly, Truven Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnoses; there were almost 80,000 cases in the community overall. Bryan and College Station each accounted for nearly 25% of the community's heart disease for each individual condition. Brenham accounted for approximately 8% of each type of cardiac disease in the community.

2015 Estimated Heart Disease Cases

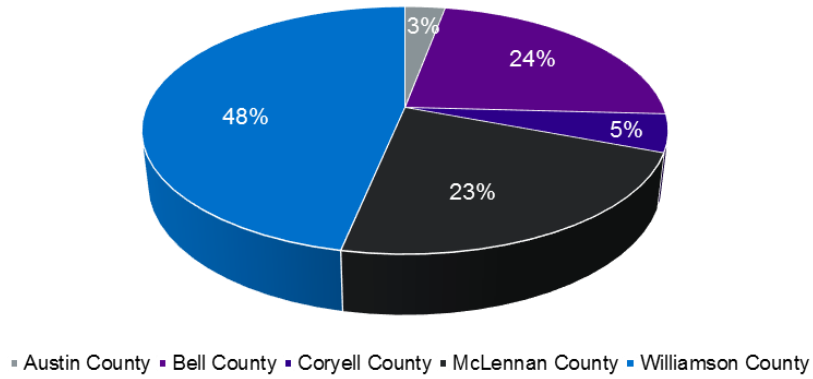
Disease Type	Austin County	Brazos County	Burleson County	Grimes County	Waller County	Washington County	Total Community
ARRHYTHMIAS	1,459	7,270	1,038	1,535	1,879	2,004	15,184
CONGESTIVE HEART FAILURE	702	2,950	519	679	821	989	6,662
HYPERTENSION	6,750	39,763	3,969	7,406	10,641	7,962	76,491
ISCHEMIC HEART DISEASE	1,239	5,918	1,132	1,541	1,641	1,559	13,030

Note: Prevalence cannot be aggregated across heart disease categories due to co-morbidity between heart disease types.

Source: Truven Health Analytics, 2015

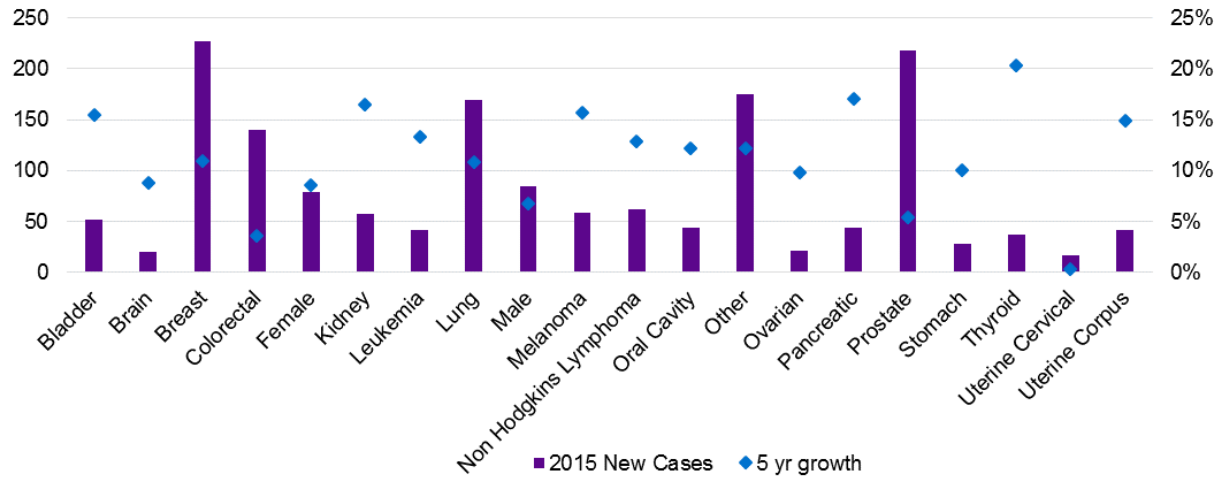
Truven Health's 2015 Cancer Estimates revealed that the fastest growing cancers in the community were pancreatic, thyroid, melanoma and kidney. Most new cancer cases were breast, prostate or lung cancers. The prevalence of cancer in the community served was 2-4% lower than the state for all cancer types.

2015 Estimated New Cancer Cases



Source: Truven Health Analytics, 2015

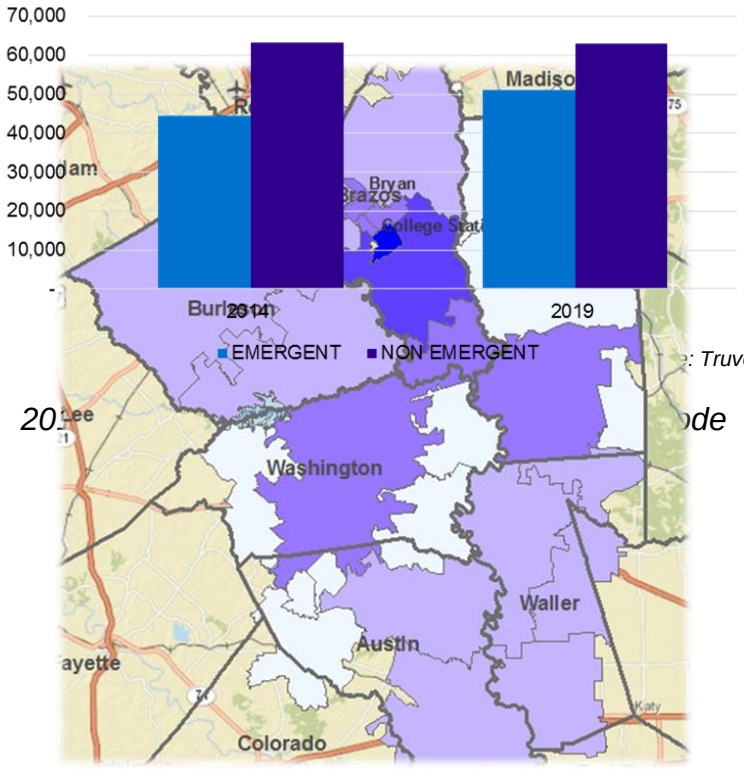
Cancer Cases and Growth by Type



Source: Truven Health Analytics, 2015

Outpatient emergency department (ED) visits are those which are treated and released and therefore do not result in an inpatient admission. Truven Health projected outpatient ED visits to increase by 6% over the next 5 years. Emergent ED visits are expected to grow 15% by 2020. Non-emergent outpatient ED visits are lower acuity visits that present to the ED but can be treated in other more appropriate and less intensive outpatient settings. Non-emergent ED visits can be an indication of systematic issues within the community regarding access to primary care or managing chronic conditions. There will be a small decrease (-1%) in non-emergent visits over the next 5 years. More than 65,000 ED visits were expected to be made by patients from College Station and Bryan.

Emergent and Non-Emergent ED Visits



Source: Truven Health Analytics, 2015

Source: Truven Health Analytics, 2015

Interviews & Focus Groups

In the interview sessions, the participants were asked to identify the factors that contribute to the current health status of the community. The factors contributing to this perceived health status included access to care, health education, poverty and health disparities.

For the community served, the top five health needs identified in the interview process included:

1. Chronic illness (diabetes, cancer, allergies, and obesity)
2. Mental/ Behavioral Health Services (ADHD, substance abuse, overall healthcare services)
3. Access challenges (public transportation and its accessibility, access to affordable health coverage)
4. Prevention (smoking cessation, vaccinations)
5. Expanding current programs (environmental health, prevention services for the uninsured)

Barriers to good health in the community include access to care, funding, lack of resources, poor mental/behavioral health, community health, cost of care and transportation. The following populations were identified as vulnerable groups that will need special attention when addressing health needs:

- Hispanic and Latino
- Mental / Behavioral Health Conditions
- Elderly
- Immigrants
- Uninsured

The focus group for this community was held at the Washington County Community Health Clinic and Faith Mission. Participants included program directors and patients from each of the clinics. The focus group was divided into 2 small groups; one small group of directors, and a second group of clinic patients.

The group that included clinic directors was asked to identify the top needs of the community. Discussions focused on community healthcare and chronic disease management of the community served.

Access to care was noted as a significant health issue across the nation. Because the clinic was open only 3 days per week, the group believed its restricted hours contributed to its under-utilization. The focus group also identified a shortage of physicians at the clinic, and indicated an additional physician was needed to serve the patient population. Despite the community having access to a clinic, public transportation was limited. Moreover, the volume of uninsured and underinsured individuals in the community added complexity to the lack of healthcare access. The focus group noted that some areas of the county did not have healthcare resources available, and many individuals were not aware of the resources that were available. Improved communication throughout the community and coordination of services among providers would better assist with providing care to disparate populations. Additional community education opportunities were identified by the group; these included programs that focused on basic health,

preventative care, healthy pregnancies and healthy food options for various cultures. Health, wellness, and prevention were also identified as a significant challenge for the community. Healthy food choices were limited, and many areas in the community were subjected to food deserts. Limited green-space and exercise facilities coupled with poor food habits and limited activity contributed to chronic conditions such as obesity and diabetes. The community's substance abuse and behavioral health issues were exacerbated by high rates of alcoholism and a lack of specialty providers, according to the focus group. The group acknowledged Baylor Scott & White Health was providing services and making healthcare improvements within the community. The Tele-Health Counseling Center increased the availability of mental health services provided at the clinic.

The focus group comprised of directors identified the following most impactful health needs:

- Obesity / diabetes
- Behavioral health / substance abuse
- Access to specialty providers
- Provider commitment to care for low income and minority populations

The group that included clinic patients was asked to identify available options for healthcare in the community and factors that would support a healthier community. Discussions focused on the needs that would support healthy lifestyles for its community members.

The clinic patient focus group noted the 13% poverty rate in Washington County; they also stated that the clinic in Brenham primarily serves a rural and indigent population. The attendees agreed that many community residents were unable to purchase insurance due to the lack of affordability; however, they were unable to qualify for Medicaid. Recent lay-offs at a local dairy had added stress to the community due to the increasing individuals that were unemployed and uninsured. The majority of racially diverse individuals served by the clinic are 18 to 64 years of age, uninsured and greater than 200% below the federal poverty level. Many reasons for delayed care or a lack of treatment exist; for example, patients were often forced to choose between buying medication to treat their illness or purchasing food for their family. Cultural and economic reasons for not seeking appropriate care existed. The focus group identified the lack of knowledge regarding preventative care, and acknowledged the ED is the preferred method of care for this population. The group recognized 2 modes of public transportation in the community, the Washington County Commuter Express (WCCE) and a shared ride taxi service. The patients mentioned that the clinic has a good reputation throughout the community; however, many residents in the community are not aware of the services provided.

The focus group comprised of patients identified the following health needs:

- Access to healthy food
- Better knowledge of the clinic and other resources
- Exercise facilities (both indoor and outdoor)

Community resources were identified by the groups to address the top needs identified. ***Appendix B*** includes the list of existing community resources identified by the participants.

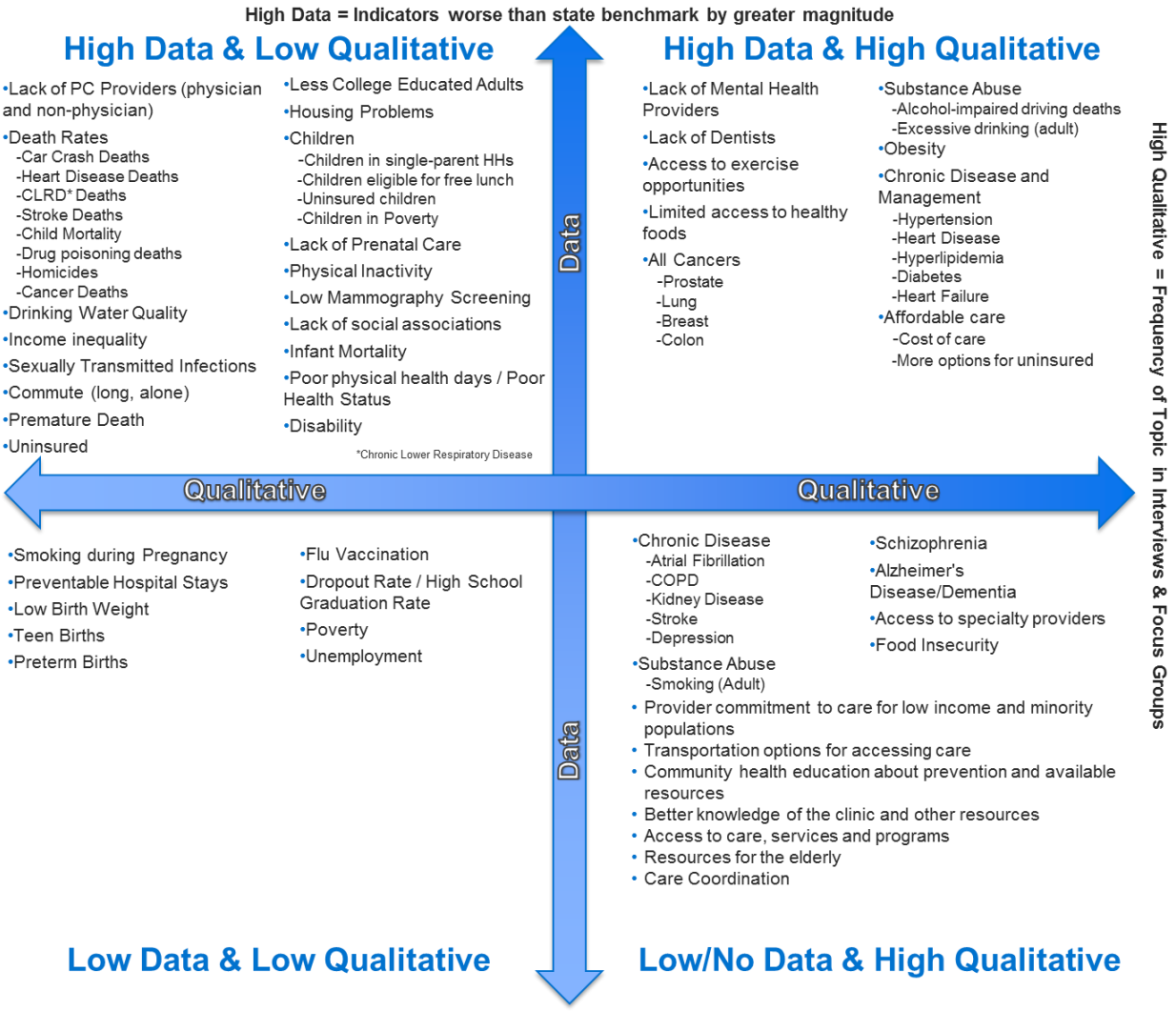
The interview and focus group participants and the populations they serve for this community are documented in the table below.

Focus Group and Key Informant Interview Participants						
Consumers	**Community Leaders/ Groups**		**Public and Other Organizations**		**Other Providers**	
Clinic Patients (Focus Group)	Burleson County Health Resource Commission (Interview) **MU**	Central Health (Focus Group)	TX A&M Agrilife Extension Office (Interview)	Texas Department of State Health Services (Interview) **PH**	S&W Brenham Community Health Clinic (Focus Group) **MU, LI, MP**	Faith Mission, WIC Program (Focus Group) **MU, LI, MP**
	City of College Station (Interview)	Catholic Charities of Central TX (Interview) **MU, LI, MP**	Helping Hands Ministry-Belton (Focus Group)	Bryan Independent School District (Interview)	Faith Mission, Community Health Clinic, MAP (Focus Group) **MU, LI, MP**	Health for All (Interview) **MU**
			College Station Independent School District (ISD) (Interview)		Faith Mission (Focus Group) **MU, LI, MP**	Community Health Clinic (Focus Group) **MU, LI, MP**

Represents Public Health	Represents Medically Underserved Populations	Represents Low Income Populations	Represents Populations with Chronic Disease Needs	Represents Minority Populations
PH	**MU**	**LI**	**CD**	**MP**

Health Needs Matrix

Both the quantitative data and qualitative data were analyzed and assembled into a Health Needs Matrix in order to help identify the most significant community health needs. Below is the matrix for the community served by the BSWH facilities.



Source: Truven Health Analytics, 2016

Prioritizing Community Health Needs

In order to identify and prioritize the significant needs of the community, the hospital facility established a comprehensive method of taking into account all available relevant data including community input.

First, specific needs were pinpointed when an indicator for the community served did not meet state benchmarks. Then an index of magnitude analysis was conducted on all those indicators to determine the degree of difference from the benchmark in order to indicate the relative severity of the issue. The outcomes of this quantitative analysis were aligned with the qualitative findings of the community input sessions to bring forth a list of health needs in the community. These health needs were then classified into one of four quadrants within a health needs matrix; high data low qualitative, low data low qualitative, low data high qualitative, or high data high qualitative.

The matrix was reviewed on January 26, 2016 by Baylor Scott & White – College Station and Brenham hospital and clinic leadership in a session to establish a list of significant needs and to prioritize them. The meeting was moderated by BSWH – Central Texas Director of Community Benefit and included an overview of the community demographics, summary of health data findings and an explanation of the quadrants of the health needs matrix.

Session participants included:

President – College Station Region	Director of Medical Staff Services	Manager Access Services
Vice President Operations, Hospital	Nursing Administration – College Station	Clinic Manager
Vice President Operations, Clinic	Emergency Department Nursing Director	Call Center
Nursing Administration – Brenham	Center for Operations Excellence	Surgical Division of Obstetrics and Gynecology
Respiratory Therapy	Facilities Director	Nursing
Clinic Operations	Chief Operations Allergy, Hematology, Oncology, Occupational Medicine	Labor and Delivery, Post-partum, Obstetrics, Gynecology, and Nursery
Marketing and Public Relations Manager	Brenham, Caldwell and Hempstead Clinic Director	Manager Neonatal Intensive Care and Pediatrics
Laboratory	Clinic Operations Primary Care	
Medical Surgical Manager	Regional Health Information Management Director	

Participants all agreed that the health needs indicated in the quadrant labeled “high qualitative, high quantitative” deserved the most attention, and there was discussion around which indicators from that quadrant should be identified as significant.

A dotmocracy[3] voting method was employed to identify the significant needs, and then to prioritize those needs. Each participant voted for only 5 of the health needs identified in the matrix. The votes were tallied and priority needs were established by the highest number of votes and are displayed in order of number of votes received.

1. Mental health
2. Chronic illness
3. Cancer
4. Obesity
5. Access to specialty providers
6. Resources for the elderly

The significant needs were prioritized based on the severity of each need as it pertains to the state benchmark, value the community places on the need and prevalence of the needs within the community.

[3] "Dotmocracy" is an established facilitation method used to describe voting with dot stickers, also known as "multi-voting". In Dotmocracy participants vote on their favorite options using a limited number of stickers or marks with pens — dot stickers being the most common. This sticker voting approach is a form of cumulative voting.

Description of Significant Health Needs

Mental Health

Mental Health was a community health need identified as a priority through the key informant interviews and focus groups. Specifically, participants mentioned that the prevalence of alcoholism in the community exacerbated substance abuse and behavioral health challenges. The participants expressed a need for services to treat specific conditions related to substance abuse and behavioral health. The group's input acknowledged the existence of a tele-health counseling program which was available to provide mental health services at the local clinic.

According to the Behavioral Risk Factor Surveillance System (BRFSS), the average number of mentally unhealthy days, which includes stress, depression, and problems with emotions, reported by adults in the past month was 3.3 in Austin County, 2.8 in Brazos and Burnet counties, and 1.6 in Washington County compared to the state value of 3.3 and the County Health Rankings Top Performer's value of 2.3 (statistics were not available for Grimes and Waller counties). The state's percent of adults that reported binge drinking in the last 30 days is 16% which was only slightly higher than the U.S. at 15%. Nineteen percent (19%) of adults in Austin County reported binge drinking in the past 30 days.

According to the CMS National Provider Identification File the number of individuals in the community served for each mental health provider was 17,169 in Burleson County, 6,715 in Grimes County, and 2,885 in Austin County compared to 1,034 residents per provider in the state and 386 among the County Health Rankings Top Performers.[4] None of the counties in the community served had a better population to mental health provider ratio than that of the state or the County Health Rankings Top Performers.

Chronic Illness

A chronic illness or disease is a disease lasting 3 months or more, by the definition of the U.S. National Center for Health Statistics. Chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear. Health damaging behaviors - particularly tobacco use, lack of physical activity, and poor eating habits - are major contributors to the leading chronic diseases[5].

Chronic illness/disease prevention and management was a concern due to the significant impact it has on the health of the community. Specifically, preventable conditions such as adult uncontrolled diabetes and obesity contribute to chronic disease and could be prevented with healthy lifestyle choices. The participants identified the need for easy access to healthy food options and support for active lives. The group provided examples of programs the community could offer to promote healthy living, which included food cooperatives, green space with structured activities, convenient access to exercise facilities, education for the community on the importance of physical activity and how to healthily prepare food.

[4] CMS National Provider Identification File, 2014, Ratio of population to mental health providers.
[5] http://www.medicinenet.com

According to the CDC Diabetes Interactive Atlas, adult diabetes incidence in Burleson County was 12%, which is the highest of the counties included in the community served and was above the state's average of 9%.[6] Brazos was the only county in the community that was below the state's benchmark. Adult, uncontrolled diabetes hospitalizations per 100,000 people were 22.1 in Grimes County and 20.1 in Washington County compared to 13.1 in the state. Both Austin County and Brazos County were below the state's benchmark according to the Texas Department of State Health Services.[7]

Cancer

Most new cancer cases in the community served were breast, prostate or lung cancers; however, the fastest growing cancers were pancreatic, thyroid, melanoma and kidney. Cancer incidence for all types per 100,000 people were lower in the community served than in the U.S., according to the National Cancer Institute.[8] The counties with the highest prevalence of cancer were Brazos (425) and Grimes (453).

Cancer was identified as a top health priority for the community served due to the low incidence of mammography screening in Medicare enrollees. According to Dartmouth Atlas of Healthcare, one half of the counties included in the community have screening rates less than both the U.S. and the state.[9] All counties fell below the state's 59% benchmark; Burleson, Grimes, and Waller counties had 49%, 49%, and 52% mammography screening by Medicare enrollees, respectively.

Obesity

Obesity and diabetes coupled with an unhealthy lifestyle were also a common theme among participants in the key informant interviews and focus group sessions. Participants noted the prevalence of "cultural beliefs and food habits," rather than a culture of living a healthy life in the community. Ethnic habits, which may be unhealthy, were difficult to modify, and food deserts in the community contributed to unhealthy eating habits. Adult exercise options remain limited and are not easily accessible. There was a need for more community activities and opportunities to exercise. The availability of education about the correlation between obesity, diabetes and a healthy lifestyle was limited.

According to the CDC, the percent of adults that reported a body mass index (BMI) of 30 or more was 29% in the state; the counties of Burleson (30%), Grimes (35%), and Waller (31%) exceeded the state.[10] According to the USDA, the percentage of low-income residents that had limited access to healthy foods was 18% in Brazos County, 16% in

[6] CDC Diabetes Interactive Atlas, 2011 Percentage of adults aged 20 and above with diagnosed diabetes (as reported via BRFSS)
[7] Texas Department of State Health Services Center for Statistics, 2013 Adult Uncontrolled Diabetes Admission Risk-Adjusted-Rate (per 100,000 population), Texas Hospital Inpatient Discharge Public Use Data File
[8] National Cancer Institute, 2008-2012 Average Annual Cancer (all-causes) Incidence
[9] Dartmouth Atlas of Healthcare, 2012, Percentage of female Medicare enrollees ages 67-69 that receive mammography screening
[10] CDC Diabetes Interactive Atlas, 2011 Percentage of adults aged 20 and above with diagnosed diabetes (as reported via BRFSS)

Grimes County, and 15% in Austin County compared to the state value of 8%.[11] Additionally, only 18% of the population in Waller County had adequate access to locations for physical activity compared to the state value of 84%; other counties in the community served that were lower than the state's benchmark included Austin (59%), Burleson (43.1%), Grimes (43%) and Washington (73%).[12]

Access to Specialty Providers

The lack of access to specialty providers provided challenges to caregivers and their patients due to the difficulty it can often cause in managing specific diseases. The focus group, comprised of clinic directors, specifically mentioned the problems patients with Hepatitis C encounter due to the lack of specialists.

Receiving care from a specialist may be more costly due to the nature of chronic conditions; therefore, when patients have limited monies available for healthcare, they often do not seek the necessary treatment from a specialty physician. According to BRFSS, 26.4% of patients in Austin County and 14.6% of patients in Brazos County did not see a doctor due to cost, compared to 19.1% in the state.[13]

Resources for the Elderly

The elderly population was the fastest growing cohort in the community served. Between 2015 and 2020, this population is projected to increase by nearly 8,000 seniors. Growth among this age group will likely contribute to increased utilization of healthcare services. Over time, the community must be able to provide adequate services to care for the aging population.

According to the Dartmouth Atlas of Healthcare, the price-adjusted Medicare reimbursements per enrollee was $10,488 in Austin County, $9,767 in Brazos County, $10,259 in Burleson County, $11,001 in Grimes County, $10,509 in Waller County, $8,020 in Washington County and $11,079 in the state. The number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees was 79.3 in Burleson County, 72.7 in Grimes County and 66.6 in Grimes County compared to 63 in the state and 41.2 among the County Health Ranking Top Performers. The remaining counties in the community served had fewer stays for ambulatory-sensitive conditions.[14]

Summary

BSWH conducted its Community Health Needs Assessments beginning July 2015 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback as well as publically available and proprietary health indicators, BSWH was able to identify and prioritize community health needs for their

[11] United States Department of Agriculture (USDA) Food Environment Atlas, 2010 percentage of population who are low-income and do not live close to a grocery store.
[12] The Business Analyst, Delorme Map Data, 2010 & 2013, percentage of population with adequate access to locations for physical activity.
[13] Behavioral Risk Factor Surveillance System (BRFSS), 2006-2012 percent of adults who could not see a doctor in the past 12 months due to cost
[14] Dartmouth Atlas of Healthcare, 2012, Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees

healthcare system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs BSWH has chosen to address for the community served.

Appendix A: Key Health Indicator Sources

Key Health Indicator Sources	
CMS Chronic condition Data Warehouse (CCW)	Center for Public Policy Priorities/ Texas Education Agency
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention	Texas Education Agency
Texas Department of state Health Services	2015 County Health Rankings
National Vital Statistics System	US Census Small Area Income and Poverty Estimates (SAIPE)
CDC Wonder mortality data Compressed Mortality File (CMF)	American Community Survey
Fatality Analysis Reporting System (FARS)	Bureau of Labor Statistics
Small Area Health Insurance Estimates	County Business Patterns
Dartmouth Atlas of Health Care	National Center for Education Statistics
Area Health Resource File/ American Medical Association	National Center for Health Statistics
CMS, National Provider Identification File	Uniform Crime Reporting, Federal Bureau of Investigation
Feeding America	Behavioral Risk Factor Surveillance System (BRFSS)
USDA Food Environment Atlas	National Cancer Institute
Safe Drinking Water Information System	CDC Diabetes Interactive Atlas
Comprehensive Housing Affordability Strategy (CHAS)	CMS

Appendix B: Community Resources Identified to Potentially Address Significant Health Needs

Resources Identified via Community Input

Area Health and Social Service Agencies	Coalition Project Unity	Health Department	Tier 1 Chronic Disease Care
Baylor Scott & White Health	County Extension Service	Local University	United Way
Baylor Scott & White Wellness Center	Free Clinics	Telehealth Counseling Clinic (TCC)	Veterans Administration
Brenham Clinic	Health 4 All	Texas Department of Assistive and Rehabilitative Services (DARS)	

Community Healthcare Facilities[15]

Hospitals – Ten (10) hospitals serving the community

Facility Name	System	Type	Street Address	City	State	ZIP
Baylor Scott & White Medical Center - Brenham	Baylor Scott & White	ST	700 MEDICAL PARKWAY	BRENHAM	TX	77833
Baylor Scott & White Medical Center - College Station	Baylor Scott & White	ST	700 SCOTT & WHITE DRIVE	COLLEGE STATION	TX	77845
Bellville St Joseph Health Center	Catholic Health Initiative	ST	44 NORTH CUMMINGS	BELLVILLE	TX	77418
Burleson St Joseph Health Center Of Caldwell Texas	Catholic Health Initiative	ST	1101 WOODSON DRIVE	CALDWELL	TX	77836
Christus Dubuis Hospital Of Bryan	CHRISTUS	ST	1600 JOSEPH DRIVE	BRYAN	TX	77802
College Station Medical Center	Community Health Sys	ST	1604 ROCK PRAIRIE ROAD	COLLEGE STATION	TX	77845
Grimes St. Joseph Health Center	Catholic Health Initiative	ST	210 SOUTH JUDSON	NAVASOTA	TX	77868
St Joseph Regional Health Center	Catholic Health Initiative	ST	2801 FRANCISCAN DRIVE	BRYAN	TX	77802
St Joseph Regional Rehabilitation Center	Catholic Health Initiative	ST	1600 JOSEPH DRIVE	BRYAN	TX	77802
The Physicians Centre Hospital	National Surgical Hospitals	ST	3131 UNIVERSITY DRIVE EAST	BRYAN	TX	77802

**Type: ST=short-term; LT=long-term, PSY=psychiatric, KID = pediatric*

Free-Standing Emergency Departments

Facility Name	Street Address	City	State	ZIP
Caprock Emergency	948 WILLIAM D FITCH	COLLEGE STATION	TX	77845
Sealy Emergency Room LLC	1036 NORTH CIRCLE DRIVE SUITE 101	SEALY	TX	77474

Psychiatric Facilities

Facility Name	Street Address	City	State	ZIP
Rock Prairie Behavioral Health	3550 NORMAND DRIVE	COLLEGE STATION	TX	77845

[15] Texas Department of State Health Services, 12/23/2015

Appendix C: Evaluation of Implementation Strategy Impact

Baylor Scott & White Medical Center – Brenham 2014-2016 Implementation Evaluation

✔	*Successful strategies and activities.*
⊘	*Partially successful strategies. Ideas good but either funding or staffing prohibited proper execution.*
✘	*Unsuccessful strategies and activities. Were unable to implement*

Significant Need: Obesity

Strategy #1: Expand efforts of educating the community on healthy living by working with nutritionists and physicians

✔ Work with dietician to develop and distribute informational materials at the Wellness Center, Health Fairs, community presentations and programs

✔ Identify additional strategies to affect hypertension in the community

Strategy #2: Texercise— an evidence based program that includes instruction on physical activity and nutrition. The program helps people adopt their own exercise routines/habits and not be dependent on the others after leaving the class

✔ Expand current programs related to exercise and nutritional management. These include Texercise and Fit and Strong

✔ Identify potential evidence-based programs to implement related to obesity including weight loss, nutrition and exercise

Strategy #3: Participate in at least 12 health fairs annually

✔ Provide health information on prevention and management of certain conditions as well as appropriate health screenings to health fair participants

Outcomes

Community Based Wellness Programs

BSWH offers free and/or reduced cost services and programs geared towards enhancing the well-being of individuals in the community including Texercise and Seniorcise.

People Served: 852
Community Benefit Expense: $12,619

Community Health Education (Other)

BSWH consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment and the treatment options available.

People Served: 37
Community Benefit Expense: $528

Community Health Education – School Based

BSWH recognizes the importance of teaching about health and health professions to students in our school systems. Programs and services in this category are geared towards students K-12.

People Served: 888
Community Benefit Expense: $436

Diabetes Education

BSWH recognizes the importance of teaching about health and health professions to students in our school systems. Programs and services in this category are geared towards students K-12.

People Served: 867
Community Benefit Expense: $18,756

Financial Contributions: Community Health Improvement

BSWH often donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education.

People Served: unknown
Community Benefit Expense: $11,435

Health Fairs - Community

BSWH regularly participates in health fairs in the communities we serve in order to provide screening and access to educational materials that will help impact healthy lifestyle habits. Completed 33 Health Fairs in 2013, 25 health fairs in 2014 and 20 health fairs in 2015

People Served: 1,409
Community Benefit Expense: $24,839

Health Fairs - Corporate

BSWH regularly participates in corporate health fairs in the business communities we serve in order to provide access to screenings and educational materials that will help impact healthy lifestyle habits.

People Served: 1,188
Community Benefit Expense: $19,917

Health Screenings

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a one-time basis or as a special event in the community and are available to those who are under insured, medically underserved or for the broader community.

People Served: 43
Community Benefit Expense: $593

Kids Day

An annual wellness event held for kids before the start of the school year. Health information, screenings, vaccines and more are provided free to all participants.to provide access to screenings and educational materials that will help impact healthy lifestyle habits.

People Served: 521
Community Benefit Expense: $7,955

Wellness Lunch & Learns

Regular lunch & learn events are held at the hospital and are open to the public. Each session includes educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment, and the treatment options available.

People Served: 499
Community Benefit Expense: $5,036

Subtotals For: Obesity

Number of Programs: 10 Persons Served: 6,304 Net Community Benefit: $102,114

Significant Need: Chronic Disease Management

Strategy #1: Touch at least 8 to 10 people each month through individual diabetes education, prevention and management programs

✔ Encourage participation in Diabetes Refresh support group

Strategy #2: Participate in at least 12 health fairs annually to provide community health education material

✔ Offer CBC and lipid profile screenings at health fair

Strategy #3: Certify staff appropriately and provide arthritis management education classes

✔ Increase promotional efforts for ongoing programs and target new populations to increase participation

Strategy #4: Host monthly classes addressing various topics related to Chronic Obstructive Pulmonary Disease (COPD)

✔ Continue offering smoking cessation classes through the Wellness Center

✔ Develop and supply educational materials at health events on: hypertension, high-cholesterol, nutrition, weight management, thyroid disease and stress management

Outcomes

Washington County Community Clinic

BSWH Brenham collaborates with Washington County and Faith Mission of Brenham to improve access and provide services to the low-income and medically underserved residents of Washington County. This is done through in kind support of resources (supplies, staff, labs, etc.) to the community clinic throughout the year.

Persons Served: 1,401
Community Benefit Expense: $149,973

Elderly Resources and Care

Financial support provided to local organizations that help provide resources, transportation and access to services that improve the health of senior citizens in the community.

Persons Served: 2,000
Community Benefit Expenses: $5,000

Flu Vaccine Clinics

BSWH regularly participates in corporate and community flu clinics for the members we serve in order to provide access to immunizations that will help impact healthy lifestyle habits

Persons served: 3,979
Community Benefit Expense: $24,115

Wellness Walk-Ins- Immunization/Vaccine

BSWH offers free and/or reduced cost immunizations and vaccines at its Wellness Clinic in Brenham to community members on a walk in basis geared towards enhancing the well-being of individuals in the community.

Persons served: 65
Community Benefit Expense: $799

Subtotals For: Disparities in Access to Care

Number of Programs: 4 Persons Served: 7,445 Net Community Benefit: $179,887

Significant Need: Resources for the Elderly

Strategy #1: Form partnership with the Senior Activity Center (SAC) to improve transportation to services for senior and increase # of participants in wellness programs

✔ Promote wellness programs on the calendar at the senior center

✘ Explore option for classes to be held at SAC for clients

✔Contribute financially to senior center construction of new building

Strategy #2: Implement and host regular Matter of Balance classes to help prevent injuries from falls

✔Target 2 Matter of Balance classes per year with 15 participants each

✔Promote wellness program availability throughout the community and internally with providers

Outcomes

Washington County Senior Activity Center Support

Financial support provided to local organizations that help provide resources, transportation and access to services that improve the health of senior citizens in the community.

Persons Served: 2,000
Community Benefit Expense: $5,000

Seniors Day

An annual event dedicated to providing services for senior citizens in the area including vaccinations, screenings and educational information.

Persons Served: 922
Community Benefit Expense: $3,210

Wellness Programs: A Matter of Balance

Many older adults experience a fear of falling. People who develop this fear often limit their activities, which can result in physical weakness, making the risk of falling even greater. A Matter of Balance: Managing Concerns About Falls is a program designed to reduce the fear of falling and increase activity levels among older adults. A Matter of Balance includes eight two-hour sessions for a small group led by a trained facilitator.

During the class, participants learn to:
View falls as controllable
Set goals for increasing activity
Make changes to reduce fall risk at home
Exercise to increase strength and balance

Persons Served: 272
Community Benefit Expense: $8,493

Wellness Programs: Seniorcise

This ongoing educational class for seniors includes stretching and strengthening in standing and sitting positions to improve flexibility, cardiovascular health, balance and strength.

Persons Served: 3,123
Community Benefit Expense: $18,905

Wellness Programs: Other Community Based

BSWH offers free and/or reduced cost services and programs geared towards enhancing the well-being of individuals in the community.

Persons Served: 218
Community Benefit Expense: $4,026

Subtotals For: Resources for the Elderly

Number of Programs: 5 Persons Served: 6,535 Net Community Benefit: $39,634

Total Number of Programs Addressing Needs:	27
Total Persons Served:	26,625
Total Net Community Benefit:	$395,001

Baylor Scott & White Medical Center – College Station
2014-2016 Implementation Evaluation

✔	*Successful strategies and activities.*
⊘	*Partially successful strategies. Ideas good but either funding or staffing prohibited proper execution.*
✘	*Unsuccessful strategies and activities. Were unable to implement*

Significant Need: Chronic Disease Management

Strategy #1: Provide Diabetes Education, Prevention and Management programs

✔ Provide diabetes education and screenings at clinics and hospitals to patients

⊘ Promote Diabetes Day's throughout the year

Strategy #2: Offer chronic disease management education materials to community members, patients and staff

✔ Host community health fairs to provide screenings and health information

⊘ Smoking cessation courses offered to patients

✔ Patient education materials for diabetes, hypertension, high cholesterol and arthritis provided through clinics and hospitals

Outcomes

Heart Disease Education

Heart disease is the leading cause of death in our communities as well as at a national level. Screenings and education assist in early detection and treatment.

Persons Served: 1,500
Community Benefit Expense: $427

Health Screenings

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a one-time basis

or as a special event in the community and are available to those who are under insured, medically underserved or for the broader community.

Persons Served: 20
Community Benefit Expense: $1,340

Health Fairs

BSWH regularly participates in health fairs all over the communities we serve in order to provide access to educational materials that will help impact healthy lifestyle habits.

Persons Served: 350
Community Benefit Expense: $2,356

For Women For Life

Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For Women For Life the Hospital provides health services, screenings and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.

Persons Served: 60
Community Benefit Expense: $17,646

Financial Donations: Community Health Improvement

BSWH donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education.

Persons Served: 1,020
Community Benefit Expense: $116,351

Community Education in the Media

BSWH staff and physicians provide regular educational pieces to various media entities. (i.e. local television stations and newspapers)

Persons Served: unknown
Community Benefit Expense: $3,094

Subtotals For: Chronic Disease Management

Number of Programs: 6 Persons Served: 2,950 Net Community Benefit: $141,214

Significant Need: Obesity

Strategy #1: Create ongoing activities for providing outreach and education to the community, patients, and staff on healthy living

- ✔ Host a community health fair to include healthy cooking demonstration
- ✔ Host weekly farmers markets

Strategy #2: Promote free and low-cost exercise and healthy living opportunities in the community and on site to staff, patients and the community at large

- ✔ Continue with sponsorship of BCS Marathon and Health Expo
- ✔ Support annual kids' marathon to promote healthy active lifestyle

Strategy #3: Step-Up and Scale-Down implemented

- ✘ Offer onsite fitness classes for community
- ✘ Train staff and promote participation of staff and community in Step Up Scale Down: 12-week program on exercise and healthy eating

Outcomes

Community Health Education

BSWH consistently looks for opportunities to educate the community on health issues to support our mission and vision. The programs and services that fall into this category extend beyond patient care activities and include services directed to both individuals and larger populations in the community. They include such things as educational information about preventive health care, lectures, or presentations held by BSWH physicians and staff about health related topics like understanding various conditions and diseases, when to seek treatment and the treatment options available.

Persons Served: 999
Community Benefit Expense: $22,454

Community Health Education – School Based

BSWH recognizes the importance of teaching about health and health professions to students in our school systems. Programs and services in this category are geared towards students K-12.

Persons Served: 45
Community Benefit Expense: $61

Financial Donations: Community Health Improvement

BSWH donates funds to local charitable, not for profit organizations whose efforts to improve community health align with the identified health needs in our community. We do so to support their efforts to improve the overall health of the community through education, prevention, health advocacy, or disease management education.

Persons Served: 1,020
Community Benefit Expense: $116,351

For Women For Life

Regular health exams and tests can help find problems before they start. They also can help find problems early, when the chances for treatment and cure are better. Through For Women For Life the Hospital provides health services, screenings, and treatments, assisting women in taking steps that help their chances for living a longer, healthier life. This annual event for women focusing on proactive health care including preventive health screenings, seminars and healthy lifestyle information.

Persons Served: 60
Community Benefit Expense: $17,646

Health Fairs

BSWH regularly participates in health fairs all over the communities we serve in order to provide access to educational materials that will help impact healthy lifestyle habits.

Persons Served: 350
Community Benefit Expense: $2,356

Health Screenings

BSWH offers screenings throughout the year to assist in the prevention and early identification of potential disease states. Some screenings are provided on a one-time basis or as a special event in the community and are available to those who are under insured, medically underserved or for the broader community.

Persons Served: 20
Community Benefit Expense: $1,340

Community Education in the Media

BSWH staff and physicians provide regular educational pieces to various media entities. (i.e. local television stations and newspapers)

Persons Served: unknown

Community Benefit Expense: $3,094

Subtotals For: Obesity

Number of Programs: 7 Persons Served: 2,494 Net Community Benefit: $163,302

Significant Need: Mental Health Services

Strategy #1: Provide behavioral health services for children, adolescents, adults and geriatrics in a seven county region.

✔ Provide quality services for patients living with Alzheimer's, Anxiety, Autism, ADD/ADHD, bipolar, personality, dissociative, eating, obsessive-compulsive, panic, posttraumatic stress and schizoaffective disorders

✔ Provide counseling for people dealing with depression, substance abuse, Tourette's syndrome, etc.

Strategy #2: Collaborate with local entities to ensure the safety, treatment and recovery of people living with mental illness

Objectives/Actions:

✔ Cultivate relationships with Brazos County Jail, Crisis Intervention Team, Brazos Valley Council for Alcohol and Substance Abuse, MHMR Brazos Valley to ensure community members receive mental health services needed

✔ Work with school districts to provide specialty care for children and their families

Outcomes

Primary Care/Behavioral Health Enhanced Services

Evaluation of new care models and establishment of protocols for behavioral health provider to be available in all BSWH primary care clinics in the community. Beginning in 2016.

Persons Served: unknown
Community Benefit Expense: unknown

Project Search

A new school-to-work program for high school students with disabilities in College Station will be offered beginning fall 2014, thanks to a cooperative effort between Scott & White Hospital, College Station Independent School District Texas Department of Assistive and Rehabilitative Services (DARS), Brazos Valley Center for Independent Living (BVCIL), MHMR Authority of Brazos Valley, Region 6 Education Service Center and Junction 505.

Project SEARCH, an international program, will place students in internships at the hospital and promote employment for students with disabilities. Students will participate in three internships to explore a variety of career paths over the course of one school year. The students work with a team that includes their family, a special education teacher and rehabilitation services to create an employment goal and support the student during this important transition from school to work.

Persons Served: 9
Community Benefit Expense: $28,328

Subtotals For: Mental Health Services

Number of Programs: 2 Persons Served: 9+ Net Community Benefit: $28,328

Total Number of Programs Addressing Needs: 16
Total Persons Served: 6,953
Total Net Community Benefit: $333,271

Appendix D: Federally Designated Health Professional Shortage Areas and Medically Underserved Areas and Populations

Health Professional Shortage Areas (HPSA)[16]

County Name	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type
Austin County	748015	Austin County	Mental Health	HPSA Geographic
Austin County	148015	Austin County	Primary Care	HPSA Geographic
Brazos County	148999485K	Brazos Valley Community Action	Primary Care	Comprehensive Health Center
Brazos County	64899948A2	Brazos Valley Community Action	Dental Health	Comprehensive Health Center
Brazos County	748999481Z	Brazos Valley Community Action	Mental Health	Comprehensive Health Center
Brazos County	748041	Brazos County	Mental Health	HPSA Geographic
Brazos County	148999483Z	Western Brazos	Primary Care	HPSA Geographic High Needs
Burleson County	748051	Burleson County	Mental Health	HPSA Geographic
Burleson County	148051	Burleson County	Primary Care	HPSA Geographic
Burleson County	648051	Burleson County	Dental Health	HPSA Geographic
Grimes County	748185	Grimes County	Mental Health	HPSA Geographic
Grimes County	14899948F8	Low Income - Grimes County	Primary Care	HPSA Population
Waller County	748473	Waller County	Mental Health	HPSA Geographic High Needs
Waller County	148473	Waller County	Primary Care	HPSA Geographic
Washington County	748477	Washington County	Mental Health	HPSA Geographic
Washington County	148477	Washington County	Primary Care	HPSA Geographic

[16] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016

Medically Underserved Areas and Populations (MUA/P)[17]

County Name	Service Area Name	MUA/P Source Identification Number	Designation Type
Austin County	Austin Service Area	3276	Medically Underserved Area
Brazos County	West Central	7192	Medically Underserved Area
Burleson County	Burleson Service Area	3289	Medically Underserved Area
Grimes County	Grimes Service Area	3338	Medically Underserved Area
Waller County	Waller Service Area	3439	Medically Underserved Area
Washington County	Washington Service Area	3441	Medically Underserved Area

[17] U.S. Department of Health and Human Services, Health Resources and Services Administration, 2016